FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031823

Facility Name: WINDMILL NURSING PAVILION

Address: 16000 SOUTH WABASH (Number) SOUTH HOLLAND (City) 60473 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3485403

Date of Initial License for Current Owners: 01/02/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	165	119	3,351	3,635	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	39,769	2,136	3,684	45,589	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,934	2,255	7,035	49,224	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.91%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/02/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/02/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 3,333

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	207,993	21,868	5,772	235,633		235,633		235,633			1
2	Food Purchase		193,452		193,452	(24,966)	168,486	(555)	167,931			2
3	Housekeeping		22,919	138,228	161,147		161,147		161,147			3
4	Laundry		13,128	77,237	90,365		90,365		90,365			4
5	Heat and Other Utilities			120,378	120,378		120,378	1,313	121,691			5
6	Maintenance	60,258	30,337	12,778	103,373		103,373	11,082	114,455			6
7	Other (specify):*			9,039	9,039		9,039	714	9,753			7
8	**TOTAL General Services**	268,251	281,704	363,432	913,387	(24,966)	888,421	12,554	900,975			8
	B. Health Care and Programs											
9	Medical Director			600	600		600		600			9
10	Nursing and Medical Records	2,005,585	70,649	4,346	2,080,580		2,080,580	(6,222)	2,074,358			10
10a	Therapy		923	885	1,808		1,808		1,808			10a
11	Activities	100,024	7,608	1,728	109,360		109,360		109,360			11
12	Social Services	91,975		1,334	93,309		93,309		93,309			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,197,584	79,180	8,893	2,285,657		2,285,657	(6,222)	2,279,435			16
	C. General Administration											
17	Administrative	126,720		61,200	187,920		187,920	52,353	240,273			17
18	Directors Fees											18
19	Professional Services			80,569	80,569		80,569	(2,450)	78,119			19
20	Dues, Fees, Subscriptions & Promotions			76,817	76,817		76,817	(61,509)	15,308			20
21	Clerical & General Office Expenses	108,732	13,071	253,649	375,452		375,452	(158,341)	217,111			21
22	Employee Benefits & Payroll Taxes			404,135	404,135	24,966	429,101		429,101			22
23	Inservice Training & Education			2,249	2,249		2,249		2,249			23
24	Travel and Seminar							109	109			24
25	Other Admin. Staff Transportation			1,489	1,489		1,489	1,748	3,237			25
26	Insurance-Prop.Liab.Malpractice			127,632	127,632		127,632	2,220	129,852			26
27	Other (specify):*			6,007	6,007		6,007	24,973	30,980			27
28	**TOTAL General Administration**	235,452	13,071	1,013,747	1,262,270	24,966	1,287,236	(140,897)	1,146,339			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,701,287	373,955	1,386,072	4,461,314		4,461,314	(134,565)	4,326,749			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WINDMILL NURSING PAVILION #0031823 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,772	
	REPAIRS & MAINTENANCE		0	
			0	5,772
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SVC		138,228	
			0	138,228
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,309	
	CONTRACTED LAUNDRY SVC		75,928	77,237
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,090	
	ELECTRICITY		59,731	
	WATER		18,896	
	CABLE TV - LOBBY		661	
			0	120,378
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,137	
	PAINTING & DECORATING		301	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		765	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,575	
	FIRE SERVICE		0	
			0	
			0	
			0	12,778
7	**OTHER**			
	SCAVENGER		9,039	
	SECURITY SERVICE		0	9,039
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	600	600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,346	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	4,346
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	177	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	332	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	288	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	88	885
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,728	
			0	1,728
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,334	
			0	1,334
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number **WINDMILL NURSING PAVILION** **#0031823** **Report Period Beginning:** **01/01/2005** **Ending:** **12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	61,200	61,200
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,554	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	76,015	
			0	80,569
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	59,032	
	EMPLOYEE WANT ADS	XIX F	4,493	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	6,507	
	LICENSES & PERMITS	XIX F	2,657	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,478	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	650	76,817
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12	
	EQUIPMENT REPAIR & MAINTENANCE		14,705	
	OUTSIDE CLERICAL SERVICES		219,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,332	
	MESSENGER SERVICE		0	
			0	253,649

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	203,941	
	UNEMPLOYMENT COMPENSATION	XIX D	46,695	
	WORKERS COMPENSATION INSURANCI	XIX D	69,384	
	HOSPITALIZATION INSURANCE	XIX D	75,766	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,349	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	404,135
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,249	2,249
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,489	1,489
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		127,632	127,632
27	**OTHER**			
	BAD DEBTS	VI 24	6,007	
				6,007

GRAND TOTAL COLUMN 3 OTHER 1,386,072

WINDMILL NURSING PAVILION
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	193,452	PATIENT MEALS	147672
LESS SALES TAX	(443)	ADD EMPLOYEE MEALS	21900
NET FOOD	193,009	TOTAL MEALS/YEAR	169572
TOTAL PATIENT CENSUS	49,224	NET FOOD	193009
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	169572
TOTAL PATIENT MEALS	147672	COST PER MEAL	1.14
		TIME EMPLOYEE MEALS	21900
ADD # EMPLOYEE MEALS/DAY	60		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	24966
TOTAL EMPLOYEE MEALS	21900		

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			60,147	60,147		60,147	142,504	202,651			30
31	Amortization of Pre-Op. & Org.							10,661	10,661			31
32	Interest			18,490	18,490		18,490	407,786	426,276			32
33	Real Estate Taxes			314,181	314,181		314,181	3,515	317,696			33
34	Rent-Facility & Grounds			843,000	843,000		843,000	(843,000)				34
35	Rent-Equipment & Vehicles			5,892	5,892		5,892	5,866	11,758			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,241,710	1,241,710		1,241,710	(272,668)	969,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,618	358,594	436,212		436,212	(1,679)	434,533			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		77,618	440,719	518,337		518,337	(1,679)	516,658			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,701,287	451,573	3,068,501	6,221,361		6,221,361	(408,912)	5,812,449			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(36,480)	30		9
10	Interest and Other Investment Income	(483)	32		10
11	Discounts, Allowances, Rebates & Refunds	(112)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(443)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,478)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(990)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,007)	27		24
25	Fund Raising, Advertising and Promotional	(59,032)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(4,500)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,525)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(297,387)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (297,387)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (408,912)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING CONSULTANT	(4,500)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,500)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION **#** 0031823 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(555)	0	0	0	0	0	0	0	0	0	0	(555)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,313	0	0	0	0	0	0	0	0	1,313	5
6	Maintenance	0	0	3,737	7,345	0	0	0	0	0	0	0	11,082	6
7	Other (specify):*	0	0	0	0	714	0	0	0	0	0	0	714	7
8	**TOTAL General Services**	(555)	0	5,050	7,345	714	0	0	0	0	0	0	12,554	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(6,222)	0	0	0	0	0	(6,222)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(6,222)	0	0	0	0	0	(6,222)	16
	C. General Administration													
17	Administrative	0	(61,200)	0	113,553	0	0	0	0	0	0	0	52,353	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,490)	308	2,732	0	0	0	0	0	0	0	0	(2,450)	19
20	Fees, Subscriptions & Promotions	(62,510)	0	1,001	0	0	0	0	0	0	0	0	(61,509)	20
21	Clerical & General Office Expenses	0	(219,600)	53,174	8,085	0	0	0	0	0	0	0	(158,341)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	109	0	0	0	0	0	0	0	0	109	24
25	Other Admin. Staff Transportation	0	0	1,748	0	0	0	0	0	0	0	0	1,748	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,220	0	0	0	0	0	0	0	0	2,220	26
27	Other (specify):*	(6,007)	0	10,981	0	19,999	0	0	0	0	0	0	24,973	27
28	**TOTAL General Administration**	(74,007)	(280,492)	71,965	121,638	19,999	0	0	0	0	0	0	(140,897)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,562)	(280,492)	77,015	128,983	20,713	(6,222)	0	0	0	0	0	(134,565)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(36,480)	176,047	2,937	0	0	0	0	0	0	0	0	142,504	30
31	Amortization of Pre-Op. & Org.	0	10,661	0	0	0	0	0	0	0	0	0	10,661	31
32	Interest	(483)	404,986	3,283	0	0	0	0	0	0	0	0	407,786	32
33	Real Estate Taxes	0	0	3,515	0	0	0	0	0	0	0	0	3,515	33
34	Rent-Facility & Grounds	0	(843,000)	0	0	0	0	0	0	0	0	0	(843,000)	34
35	Rent-Equipment & Vehicles	0	0	5,866	0	0	0	0	0	0	0	0	5,866	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(36,963)	(251,306)	15,601	0	0	0	0	0	0	0	0	(272,668)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,679)	0	0	0	0	0	(1,679)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(1,679)	0	0	0	0	0	(1,679)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,525)	(531,798)	92,616	128,983	20,713	(7,901)	0	0	0	0	0	(408,912)	45

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING SERVICES	$ 219,600	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (219,600)	1
2	V	17	MANAGEMENT FEES	61,200	" " "			(61,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	843,000	16000 S. WABASH PARTNERSHIP			(843,000)	7
8	V	30	DEPRECIATION		" " "		176,047	176,047	8
9	V	31	AMORTIZATION		" " "		10,661	10,661	9
10	V	32	INTEREST		" " "		404,986	404,986	10
11	V	19	LEGAL & ACCOUNTING		" " "		308	308	11
12	V								12
13	V								13
14	Total			$ 1,123,800			$ 592,002	$ * (531,798)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,313	$ 1,313	15
16	V	6	REPAIR & MAINT.		" " "		3,737	3,737	16
17	V	19	PROFESSIONAL FEES		" " "		2,732	2,732	17
18	V	20	DUES AND SUBSCRIPTION		" " "		1,001	1,001	18
19	V	21	CLERICAL & GENERAL		" " "		53,174	53,174	19
20	V	24	SEMINARS AND TRAVEL		" " "		109	109	20
21	V	25	AUTO EXPENSE		" " "		1,748	1,748	21
22	V	26	INSURANCE		" " "		2,220	2,220	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "		10,981	10,981	23
24	V	30	DEPRECIATION		" " "		2,937	2,937	24
25	V	32	INTEREST		" " "		3,283	3,283	25
26	V	33	REAL ESTATE TAXES		" " "		3,515	3,515	26
27	V	35	EQUIPMENT RENTAL		" " "		5,866	5,866	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 92,616	$ * 92,616	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 7,345	$ 7,345	15
16	V	17	ADMIN. CMP. - M. MAUER		" " "		20,273	20,273	16
17	V	17	ADMIN. CMP. - M. AARON		" " "		22,652	22,652	17
18	V	17	ADMIN. CMP. - F. AARON		" " "		15,064	15,064	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "				19
20	V	17	ADMIN. CMP. - S. KOPLIN		" " "				20
21	V	17	ADMIN. CMP. - D. MAGAFAS		" " "		13,952	13,952	21
22	V	17	ADMIN. CMP. - S. LEVY		" " "		18,861	18,861	22
23	V	17	ADMIN. CMP. - HOWARD ALTER		" " "				23
24	V	17	ADMIN. CMP. - NON-OWNER		" " "		22,751	22,751	24
25	V	21	CLERICAL. CMP. - S. AARON		" " "		8,085	8,085	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 128,983	$ * 128,983	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 714	$ 714	15
16	V	27	EMP.BEN. - M. MAUER		" " "		1,387	1,387	16
17	V	27	EMP. BEN. - M. AARON		" " "		1,803	1,803	17
18	V	27	EMP. BEN. - F. AARON		" " "		7,199	7,199	18
19	V	27	EMP. BEN. - S. GOLDSTEIN		" " "				19
20	V	27	EMP. BEN. - S. KOPLIN		" " "				20
21	V	27	EMP. BEN. - D. MAGAFAS		" " "		1,129	1,129	21
22	V	27	EMP. BEN. - S. LEVY		" " "		2,957	2,957	22
23	V	27	EMP. BEN. - H. ALTER		" " "				23
24	V	27	EMP. BEN. - NON-OWNER		" " "		3,733	3,733	24
25	V	27	EMP. BEN. - S. AARON		" " "		1,791	1,791	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 20,713	$ * 20,713	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS		$	$	15
16	V	19	PROFESSIONAL FEES		" " "				16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	21,337	LINCOLN MEDICAL SUPPLIES, INC.		15,115	(6,222)	21
22	V	39	ANCILLARY EXPENSE	5,758	" " "		4,079	(1,679)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,095			$ 19,194	$ * (7,901)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 20,273	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	22,652	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	15,064	17-7	3
4	" "		ADMINISTRATIVE					SALARY	20,750	21-1	4
5	" "		ADMINISTRATIVE					MGMT FEE	19,200	17-3	5
6	SHARON AARON		CLERICAL					SALARY	8,085	17-7	6
7	DENNIS NEHMER		MAINTENANCE					SALARY	7,345	17-7	7
8	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	13,952	17-7	8
9	" "		ADMINISTRATIVE					SALARY			9
10											10
11											11
12											12
13								TOTAL	$ 127,321		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	413,836	12	$ 11,039	$	49,224	$ 1,313	1
2	6	REPAIR & MAINT.	" "	413,836	12	31,419		49,224	3,737	2
3	19	PROFESSIONAL FEES	" "	413,836	12	22,969		49,224	2,732	3
4	20	DUES AND SUBSCRIPTION	" "	413,836	12	8,420		49,224	1,001	4
5	21	CLERICAL & GENERAL	" "	413,836	12	447,045	345,326	49,224	53,174	5
6	24	SEMINARS AND TRAVEL	" "	413,836	12	917		49,224	109	6
7	25	AUTO EXPENSE	" "	413,836	12	14,696		49,224	1,748	7
8	26	INSURANCE	" "	413,836	12	18,661		49,224	2,220	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	413,836	12	92,321		49,224	10,981	9
10	30	DEPRECIATION	" "	413,836	12	24,690		49,224	2,937	10
11	32	INTEREST	" "	413,836	12	27,602		49,224	3,283	11
12	33	REAL ESTATE TAXES	" "	413,836	12	29,555		49,224	3,515	12
13	35	EQUIPMENT RENTAL		413,836	12	49,319		49,224	5,866	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 778,653	$ 345,326		$ 92,616	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 55,120	$ 55,120	5	$ 7,345	1
2	17	ADMIN. CMP. - M. MAUER	" "	40	12	170,000	170,000	5	20,273	2
3	17	ADMIN. CMP. - M. AARON	" "	40	12	170,000	170,000	5	22,652	3
4	17	ADMIN. CMP. - F. AARON	" "	47	12	88,500	88,500	8	15,064	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	12	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	" "	40	12	72,485	72,485			6
7	17	ADMIN. CMP. - D. MAGAFAS	" "	45	12	104,642	104,642	6	13,952	7
8	17	ADMIN. CMP. - S. LEVY	" "	45	12	158,233	158,233	5	18,861	8
9	17	ADMIN. CMP. - H. ALTER	" "	40	12	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	" "	45	12	170,636	170,636	6	22,751	10
11	21	CLERICAL. CMP. - S. AARON	" "	40	12	67,785	67,785	5	8,085	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,093,401	$ 1,093,401		$ 128,983	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 5,362	$	5	$ 714	1
2	27	EMP.BEN. - M. MAUER	" "	40	12	11,631		5	1,387	2
3	27	EMP. BEN. - M. AARON	" "	40	12	13,532		5	1,803	3
4	27	EMP. BEN. - F. AARON	" "	47	12	42,295		8	7,199	4
5	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	33,649				5
6	27	EMP. BEN. - S. KOPLIN	" "	40	12	25,376				6
7	27	EMP. BEN. - D. MAGAFAS	" "	45	12	8,470		6	1,129	7
8	27	EMP. BEN. - S. LEVY	" "	45	12	24,807		5	2,957	8
9	27	EMP. BEN. - H. ALTER	" "	40	12	1,105				9
10	27	EMP. BEN. - NON-OWNER	" "	45	12	27,997		6	3,733	10
11	27	EMP. BEN. - S. AARON	" "	40	12	15,016		5	1,791	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 209,240	$		$ 20,713	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			15,115			15,115	9
10	39	ANCILLARY EXPENSE	" "			4,079			4,079	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 19,194	$		$ 19,194	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK ONE		X	MORTGAGE	$55,898.81	10/00	$ 5,625,000	$ 4,471,829		8.6500	$ 404,986	1
2												2
3												3
4												4
5	RELATED PARTY										3,283	5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	DEMAND			200,000		PRIME+	13,063	6
7			X	INSURANCE FINANCING							2,898	7
8	FORD CREDIT		X	VAN	$859.00	7/04	51,540	36,078	7/09	6.9900	2,529	8
9	TOTAL Facility Related				$56,757.81		$ 5,676,540	$ 4,707,907			$ 426,759	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,676,540	$ 4,707,907			$ 426,759	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	308,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	305,181	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,819)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	317,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	314,181	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	244,044	8
2001	269,495	9
2002	277,542	10
2003	293,113	11
2004	305,181	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDMILL NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	NURSING HOME	$ 305,180.84	$ 305,180.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 305,180.84	$ 305,180.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 408,821	1
2					2
3	TOTALS			$ 408,821	3

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1986	1976	$ 3,187,988	$ 153,106	30	$ 106,266	$ (46,840)	$ 1,700,256	4
5					722,629	22,941		22,941			5
6											6
7											7
8	RELATED PARTY					1,353		1,508	155		8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1989	6,334	201	31.5	201		3,308	9
10	LEASEHOLD IMPROVEMENT			1990	1,538	49	20	77	28	961	10
11	LEASEHOLD IMPROVEMENT			1991	26,695	847	20	1,335	488	16,192	11
12	LEASEHOLD IMPROVEMENT			1992	4,785	152	20	239	87	2,748	12
13	LEASEHOLD IMPROVEMENT			1993	8,024	255	31.5	255		3,255	13
14	LEASEHOLD IMPROVEMENT			1993	36,822	944	39	944		11,669	14
15	LEASEHOLD IMPROVEMENT			1994	38,826	996	39	996		11,149	15
16	LEASEHOLD IMPROVEMENT			1995	21,539	553	39	553		5,896	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR			1996	1,604	41	39	41		402	17
18	ROOF REPAIR			1996	3,800	98	39	98		919	18
19	GAZEBO			1996	1,282	33	39	33		309	19
20	ASPHALT REMOVE & REPLACE			1996	2,686	69	39	69		642	20
21	ROOF REPAIR			1996	7,000	180	39	180		1,665	21
22	HOT WATER TANK			1996	12,098	309	39	309		2,828	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844	176	39	176		1,452	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092	2,701	39	2,701		22,422	24
25	ROOFING			1997	45,500	1,169	39	1,169		9,679	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721	121	39	121		1,003	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497	670	39	670		5,621	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359	85	39	85		638	28
29	DRAPES & INSTALLATION			1998	5,965	153	39	153		1,126	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS			1998	14,240	365	39	365		2,689	30
31	EXHAUST FAN & INSTALLATION			1998	2,285	59	39	59		425	31
32	ROOF REPAIR			1998	8,750	224	39	224		1,654	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500	577	39	577		4,271	33
34	ELECTRICAL WORK			1998	5,376	138	39	138		1,015	34
35	COUNTER TOPS			1998	712	18	39	18		132	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT IMPROVEMENT	1998	$ 1,185	$ 31	39	$ 31	$	$ 212	37
38	NURSES STATION	1999	16,601	425	39	425		2,964	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		752	39
40	FIRE SYSTEM	1999	2,625	67	39	67		465	40
41	FLOOR TILE	1999	10,807	277	39	277		1,928	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		1,654	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		1,473	43
44	AIR CONDITIONING	1999	14,451	371	39	371		2,484	44
45	RAILINGS	1999	3,282	84	39	84		557	45
46	ROOF WORK	1999	4,500	115	39	115		724	46
47	NURSE STATION	2000	7,090	258	27.5	258		1,431	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		1,285	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		1,693	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		521	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		698	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	229	15	418	189	1,881	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		902	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		919	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		461	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	209	27.5	209		914	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		382	57
58	CONCRETE PAD	2002	1,662	90	15	111	21	387	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		87	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		423	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		681	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		204	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		189	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		718	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		203	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		1,009	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		720	67
68	AIR CONDITIONING	2004	664	24	27.5	24		35	68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,529,875	$ 194,861		$ 148,989	$ (45,872)	$ 1,843,282	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,529,875	$ 194,861		$ 148,989	$ (45,872)	$ 1,843,282	1
2	WATER HEATER,VALVE & PUMPS	2004	6,594	240	27.5	240		350	2
3	FIRE DOORS	2004	769	28	27.5	28		41	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	127	27.5	127		127	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	177	27.5	177		177	5
6	FIRE ALARM REPAIRS	2005	1,449	24	27.5	24		24	6
7	WALL AIR CONDITIONER	2005	1,892	31	27.5	31		31	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,558,803	$ 195,488		$ 149,616	$ (45,872)	$ 1,844,032	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 436,350	$ 29,705	$ 39,200	$ 9,495	10	$ 248,632	71
72	Current Year Purchases	29,366	5,461	1,468	(3,993)	10	1,468	72
73	Fully Depreciated Assets	198,693					198,693	73
74			262	2,369	2,107			74
75	TOTALS	$ 664,409	$ 35,428	$ 43,037	$ 7,609		$ 448,793	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2004 FORD E-450		$ 43,085	$ 6,893	$ 8,617	$ 1,724	5	$ 12,926	76
77										77
78	RELATED PARTY				1,322	1,381	59			78
79										79
80	TOTALS			$ 43,085	$ 8,215	$ 9,998	$ 1,783		$ 12,926	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,675,118	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 239,131	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 202,651	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (36,480)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,305,751	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,892 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number WINDMILL NURSING PAVILION STATE OF ILLINOIS # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 176,681	$		$ 176,681	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,144			6,144	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			175,769			175,769	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				64,004		64,004	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY,LABORATORY Other (specify): SUPPLIES	39-2					13,614		13,614	13
14	TOTAL			$		$ 358,594	$ 77,618		$ 436,212	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 215,962	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (56,316))	1,149,556		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,643		6
7	Other Prepaid Expenses	7,335		7
8	Accounts Receivable (owners or related parties)	65,124		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,509,620	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	648,186		15
16	Equipment, at Historical Cost	707,494		16
17	Accumulated Depreciation (book methods)	(774,016)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSIT	9,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 590,664	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,100,284	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 262,555	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	236,078		29
30	Accrued Salaries Payable	216,721		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,176		31
32	Accrued Real Estate Taxes(Sch.IX-B)	317,000		32
33	Accrued Interest Payable	913		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,049,443	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,049,443	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,050,841	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,100,284	$	48

***(See instructions.)**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 749,836	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 749,836	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	301,005	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 301,005	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,050,841	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,242,610	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,242,610	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,161	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 279,161	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	483	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 483	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	112	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 112	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,522,366	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	913,387	31
32	Health Care	2,285,657	32
33	General Administration	1,262,270	33
	B. Capital Expense		
34	Ownership	1,241,710	34
	C. Ancillary Expense		
35	Special Cost Centers	436,212	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,221,361	40
41	**Income before Income Taxes (line 30 minus line 40)****	301,005	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 301,005	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,940	2,166	$ 79,457	$ 36.68	1
2	Assistant Director of Nursing	3,441	3,882	90,801	23.39	2
3	Registered Nurses	3,572	3,717	98,401	26.47	3
4	Licensed Practical Nurses	35,410	38,742	793,898	20.49	4
5	CNAs & Orderlies	85,007	91,518	920,518	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,885	2,064	23,612	11.44	9
10	Activity Assistants	8,869	9,374	76,412	8.15	10
11	Social Service Workers	5,196	5,646	91,975	16.29	11
12	Dietician					12
13	Food Service Supervisor	1,913	2,150	35,734	16.62	13
14	Head Cook	2,049	2,212	25,816	11.67	14
15	Cook Helpers/Assistants	15,576	17,118	146,443	8.55	15
16	Dishwashers					16
17	Maintenance Workers	3,776	4,082	60,258	14.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,893	2,174	73,553	33.83	20
21	Assistant Administrator	2,348	2,574	53,167	20.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,681	7,311	108,732	14.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,736	2,021	22,510	11.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,292	196,751	$ 2,701,287 *	$ 13.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,772	1-3	35
36	Medical Director		600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,346	10-3	39
40	Physical Therapy Consultant		177	10a-3	40
41	Occupational Therapy Consultant		332	10a-3	41
42	Respiratory Therapy Consultant		288	10a-3	42
43	Speech Therapy Consultant		88	10a-3	43
44	Activity Consultant	33	1,728	11-3	44
45	Social Service Consultant	24	1,334	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	57	$ 14,665		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANN MARIE HARRINGTON	ADMIN		$ 73,553
JOYCE MCGEE	ASST ADMIN		53,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 126,720

B. Administrative - Other

Description	Amount
DYNAMIC HEALTH CARE	$ 42,000
FRED AARON	19,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 61,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		80,569
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 80,569

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,384
Unemployment Compensation Insurance	46,695
FICA Taxes	203,941
Employee Health Insurance	75,766
Employee Meals	24,966
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	8,349
TOTAL (agree to Schedule V, line 22, col.8)	$ 429,101

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,493
Health Care Worker Background Check	650
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	59,032
TRUST/FRANCHISE/CONTRIB/ETC	3,478
LICENSES & PERMITS	2,657
DUES & SUBSCRIPTIONS	6,507
MGMT CO ALLOCATION	1,001
TRUST/FRANCHISE/CONTRIB/ETC	(3,478)
Less: Public Relations Expense	(0)
Non-allowable advertising	(59,032)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,308

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCTION	109
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 109

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $5633**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,083** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,966** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees